



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
04843
75

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County CarrollCity or town Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

Baltimore - Hanover Pike, Manchester, Md.

How long in hospital or institution?

3. (a) FULL NAME Steiner Stoner Black4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife John Martin Black6.(c) If alive, give age 72 years7. Birth date of deceased (mo. day. yr.) Dec. 4, 18808. AGE: Years 67 Months 5 Days 17 If less than one dayhrs. min. 9. Birthplace York Co. Pennsylvania

(Town, County, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Henry Steiner

13. Birthplace

14. Maiden name Lorraine Bang

15. Birthplace

16. Informant Mr. John M. BlackAddress Manchester, Md17. Burial Date thereof 5. 25. 48
(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory GreenlawnLocation Stone Church Park B. & B.18. Funeral director Jacob W. Miller SonsAddress Manchester, Md19. Date rec'd by registrar May 22 194819. Date rec'd by registrar May 22 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty CarrollCity or town Manchester, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore - Hanover Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-18-48 to 5-21 1948and that I last saw her alive on 5-21 1948Immediate cause of death cardio - respiration DURATIONstop failure + acutesubmucous edemaDue to Hypertensive cardio -vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John Hays Rosser M.D.

M. D. or other

Address University HospitalBaltimore, Md Date signed 5-21-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04844

Reg. Dist. No. 74

CERTIFICATE OF DEATH

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County..... Carroll
 City or town..... Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 months, 4 days
 Hospital, Institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution?..... 10 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Kent
 City or town..... Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

3. (a) FULL NAME

IONE BLACKISTON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years
 7/2/12

8. AGE: Years	Months	Days	It less than one day
35	10	19	hrs. min.

9. Birthplace..... Kent County, Maryland
 (Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Sarah

15. Birthplace..... Unknown

16. Informant..... Record, Springfield State Hospital

Address..... Sykesville, Maryland

17. Burial..... Date thereof..... May 23 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Wesley Chapel

Location..... Rock Hall Kent Co. Maryland

18. Funeral director..... Marvin L. Williams

Address..... Chestertown Maryland

19. Date rec'd by registrar..... May 21 1948

(Date rec'd by registrar) (month) (day) (year)

Registrar

MEDICAL CERTIFICATION

DST

20. DATE OF DEATH..... May 21 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 17, 1947, to May 21, 1948.

and that I last saw her alive on May 20, 1948.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION

1 yr.

Due to.....

Due to.....

Other conditions..... Schizophrenia, paranoid type
 (Include pregnancy within 8 months of death)

14 years

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

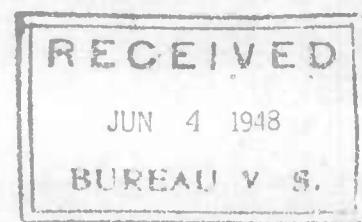
Means of injury..... Injured at work?

23. SIGNATURE..... Joseph H. Marshall, M.D.

M.D. or other

Address..... Sykesville, Maryland Date signed..... 5/21/48





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04846

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Sykesville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 17 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

3. (a) FULL NAME

Harry Walter Bosley

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Fannie Bverly

7. Birth date of deceased (mo. day, yr.) June 26, 1871

8. AGE: Years 76 Months 10 Days 12 It less than one day hrs. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual occupation Attendant

11. Industry or business Filling Station (retired)

12. Name Joshua Nelson Bosley

13. Birthplace Baltimore Co.

14. Maiden name Sarah Brummel

15. Birthplace Baltimore County

16. Informant Records of Springfield State
Address Sykesville, Md Hospital17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hampstead

Location Carroll Co Md

18. Funeral director Edwin A. Tipton

Address Hampstead, Md

19. May 9, 1948 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1948

19. at 2:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1947, 19, to May 8, 1948

and that I last saw him alive on May 8, 19, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

10 yrs

Due to Gen'l Arterio-Scleriosis

10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

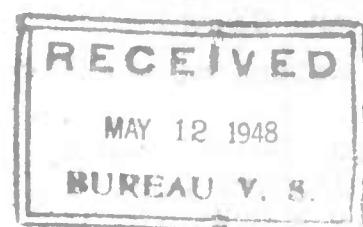
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sykesville, Md Date signed May 8, 1948





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Due correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04847

CERTIFICATE OF DEATH

Reg. Dist. No. 748

1. PLACE OF DEATH:

County... Carroll

City or town... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 1 month 3 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 yrs. 1 month 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... -

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -

(If rural, give LOCATION)

2.(a) If veteran, name war. - - -

3. (b) Social Security Number

705-05-6734

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1948 at 2:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1944 to May 5 1948

and that I last saw her alive on May 5 1948

Immediate cause of death.

Chronic myocarditis and myocardial degeneration

DURATION

more than 5 years

Due to. - - -

Due to. - - -

Other conditions Arteriosclerosis.)

6 yrs.

Senile psychosis)

(Include pregnancy within 3 months of death)

Major findings of operations. - - -

Date of op. - - -

Autopsy results. - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE M. N. Martin, M. D. M. D. or other

Address... Sykesville, Maryland Date signed 5/5/48

19. Date rec'd by registrar

(Date rec'd by registrar)

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age and birthdate shown on:

FILE NO. G-115 MAY 18 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

PC

04848

93d

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Carroll

City or town... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 months 18 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr. 5 months 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... - - -

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3726 Park Heights Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war... - - -

3. (a) FULL NAME

Byrne, Christopher Joseph

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unkn.

6.(b) Name of husband or wife... - - -

7. Birth date of deceased (mo., day, yr.) December 26, 1860

6.(c) If alive, give age... - - - years

8. AGE: Years	Months	Days	If less than one day
74 68	4	8 10	hrs. min.

9. Birthplace... Ireland

(Town, county, and state)

10. Usual occupation... landscape gardener

11. Industry or business... - - -

MOTHER FATHER 12. Name... John Joseph Byrne

13. Birthplace... Ireland

14. Maiden name... Mary Meaghan

15. Birthplace... Ireland

16. Informant... Records of Springfield St. Hospital

Address... Sykesville, Maryland

Burial Date thereof... 5/7/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Marys Govans

Location... Homeland Ave.

18. Funeral director... Wm. J. Tickner & Sons

Address... North & Pa. Ave

19. May 6, 1948

(Date rec'd by registrar)

20. May 6, 1948

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 1, 1948, at 12:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1, 1947, to May 3, 1948,

and that I last saw him alive on May 3, 1948.

Immediate cause of death...

Chronic myocarditis and myocardial degeneration

Due to... - - -

Due to... - - -

Other conditions... Jaundice

possible cancer of the liver

(Include pregnancy within 3 months of death)

Major findings of operations... - - -

Date of op... - - -

Autopsy results... - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... - - - Date of... - - -

Where did injury occur? - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) - - -

Means of injury... - - -

Injured at work? - - -

23. SIGNATURE

Martin Gross, M. D. M. D. or other

Address... Sykesville, Maryland

5/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04849

CERTIFICATE OF DEATH

Reg. Distr. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton, Md.

3. (a) FULL NAME

WILLIAM HENRY CAIN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

colored

married

6. (b) Name of husband or wife

Doris Cain6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

May 15, 1912

8. AGE:

Years

Months

Days

If less than one day

36

0

4

hrs.

min.

9. Birthplace

Rocky Mountain, N. C.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Blunt King

MOTHER FATHER

12. Name

North Carolina

13. Birthplace

Charlotte Hines

14. Maiden name

North Carolina

15. Birthplace

Deceased

16. Informant

Address

Henryton, Md.

17. Burial

Date thereof May 23, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mount Auburn CemeteryLocation Baltimore City, Maryland

18. Funeral director

Joseph A. LavelleAddress 66 West Main St Baltimore Md

19. (Date rec'd by registrar)

19. 48

Albert R. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town BaltimoreStreet 331 N. Pearl Street

(If outside city or town limits, write RURAL and give nearest town)

Street No. 331 N. Pearl Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

379-07-1736

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 19, 1948 at 5.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 16, 1948 to May 19, 1948

and that I last saw him alive on

May 19,

19. 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

November 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Wofford, M.D.

M. D. or other

Address

Henryton, Md.

Date signed

5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04850

CERTIFICATE OF DEATH

830
Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Burrall

City or town

Uniontown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 week

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lizzie Cedella Pace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

6. (b) Name of husband or wife

Albert Pace

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.)

May 10 - 1869

8. AGE: Years

79 - 17

Months

Days

if less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Seuf.

11. Industry or business

Cornelius Tracy

12. Name

Sarah Brown

13. Birthplace

Md

14. Maiden name

Sarah Brown

15. Birthplace

Md

16. Informant

Mr. Albert Pace

Address

Uniontown Md

17. Burial

Burial

Date thereof May 30 48

(month) (day) (year)

Cemetery or crematory

Baltimore

Location

Baltimore Md

18. Funeral director

Edw. C. Shipton

Address

Hampstead Md

19. Date rec'd by registrar

May 30 1948

(Date rec'd by registrar)

Margaret R. English

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Uniontown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 27 1948 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 22 1948 to May 27 1948

and that I last saw her alive on May 26 1948

Immediate cause of death

Cerebral Hemorrhage

Due to

Cerebral Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

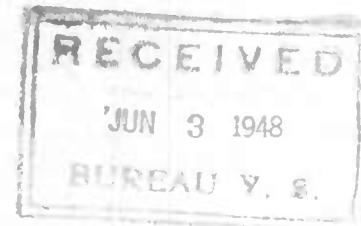
23. SIGNATURE

J. V. Legg

M. D. or other

Address

Date signed 5/27/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04851

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
County Carroll
City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

400 E. Main

How long in hospital or institution?

3. (a) FULL NAME

Albert Vincent Cover

4. Sex

m

5. Color or race

w.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lucetia Pauline Smith6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) July 28 - 18758. AGE: Years 72 Months 10 Days 1 If less than one dayhrs. min. 9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Farmer Ret.

11. Industry or business

12. Name Peter H. Cover13. Birthplace md.14. Maiden name Elizabeth Gresswell15. Birthplace md.16. Informant Lucetia P. CoverAddress 400 E. Main, Westminster, Md.17. Burial Date thereof June 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pine Brook CemeteryLocation Westminster, Md.18. Funeral director H. Burkhardt & SonAddress Westminster, Md.19. X 31 1948 4:00 a.m.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State md. County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 400 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

216-14-3965

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1948 at 12 m21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 1948 to May 29 1948and that I last saw deceased alive on May 28 1948Immediate cause of death acute cardiacRelatation relatives DURATION 10m.Due to Chronic Myocarditis 6 mos.and Hyperthyroidism 6 mos.Due to Other conditions

(Include pregnancy within 3 months of death)

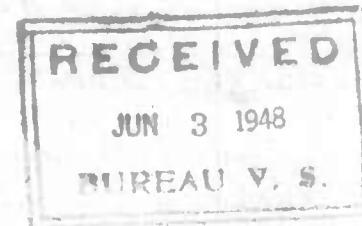
Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE John R. Foote, M.D. Date signed 5-31-48Address Westminster, Md.

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04852

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-46-15M

1. PLACE OF DEATH:

County..... *Carroll*City or town..... *Hagerstown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 yrs 7 mo 22 days*

Hospital, institution, or street address where death occurred

*Springfield State Hospital*How long in hospital or institution? *3 yrs 7 mo 22 days*

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

W *Widowed*6. (b) Name of husband or wife *William Wallace Crawford*

7. Birth date of deceased (mo., day, yr.)

May 25th 1878

6. (c) If alive, give age years

8. AGE:

Years *69* Months *11* Days *6*

If less than one day hrs. min.

9. Birthplace

(Town, county, and state) *Hagerstown*

10. Usual occupation

Housekeeper

11. Industry or business

John Evertly at home

12. Name

John Evertly

13. Birthplace

Hagerstown

14. Maiden name

Susan Wolfe

15. Birthplace

Hagerstown

16. Informant

John Evertly

Address

149 Spruce St Hagerstown

17. Burial

Burial

(Burial, cremation, or removal, which?)

Date thereof *May 10th 48*

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

C. L. Lummis Co. Ralph W. Martin

Address

*Hagerstown Md.*19. *May 7 1948*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County *Washington*

City or town

Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 7th 1948* at *10 a.m.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Sept 14 1944* to *May 7th 1948* and that I last saw him alive on *May 7th 1948*

Immediate cause of death

*Coronary Occlusion*Due to *Cerebral Arterio Sclerosis*Due to *Hypertension*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

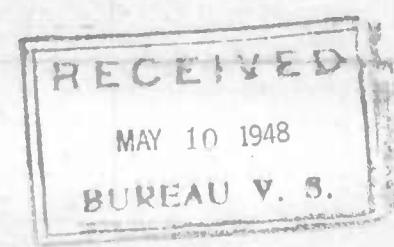
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. F. Gaston* M. D. or other *8/1/48*Address *Hagerstown Md.* Date signed *8/1/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

130

04853

76

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. Formerly Carroll Co.,
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
214-16-1663

3. (a) FULL NAME

Theodore Cummings

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced
widower

6.(b) Name of husband or wife Annie K. Cummings

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) Sept. 6, 1866

8. AGE: Years 81 Months 8 Days 3 If less than one day
hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation School Janitor

11. Industry or business School Janitor

MOTHER FATHER
12. Name Jacob Cummings

13. Birthplace Md

14. Maiden name Matilda Powell

15. Birthplace Md

16. Informant Jesse P. Cummings

Address Finksburg, Md. R#1

17. Burial Baust
(Burial, cremation, or removal. Which?) Date thereof May 12, 1948
(month) (day) (year)

Cemetery or crematory Baust
Location Tyrone, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. May 1948 19.....
(Date rec'd by registrar)

May 1948
29
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1948 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1948 to May 9, 1948 and that I last saw him alive on May 8, 1948.

Immediate cause of death acute Cardiac dilatation

Due to Acute Anterstitial Nephritis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

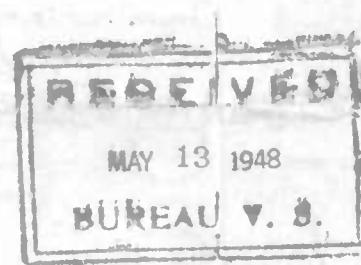
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Lehas, R. Foutz, M.D. or other

Address Westminster, Md. Date signed May 9, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04854

Reg. Dist. No.

74

1. PLACE OF DEATH:

County.....

City or town.....

Carrolls

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 4 mo 7 da

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr 4 mo 7 da

3. (a) FULL NAME

4. Sex

M

5. Color of race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

George Damuth

7. Birth date of deceased (mo., day, yr.)

May 12th 1870

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

77 11 27 hrs. min.

9. Birthplace.....

(Town, county, and state) Frederick

10. Usual occupation.....

Housewife

11. Industry or business

Cornelius At Spring

12. Name

Cornelius Black

13. Birthplace

Frederick

14. Maiden name

Amelia Young

15. Birthplace

Frederick

16. Informant

Lester Damuth

Address

Committebury Rd

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof May 11, 1948

(month) (day) (year)

Cemetery or crematory

United Brethren Cem.

Location

Elmwood, Md.

18. Funeral director

M. R. Etelson & Son

Address

Frederick, Md.

19. Date rec'd by registrar

May 9, 1948

Stanley Keer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Frederick

City or town.....

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8th 1948, at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 8th 1947, to May 8th 1948

and that I last saw her alive on May 8th 1948

Immediate cause of death.....

Cerebral Hemorrhage 1st

Due to.....

Gen. Arterio Sclerosis 3 yrs

Other conditions.....

Hypertension 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

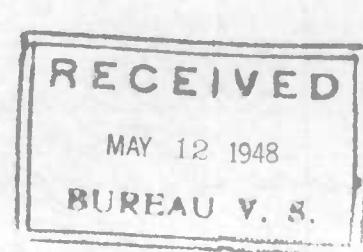
Means of injury..... Injured at work?

23. SIGNATURE

John Mastin, M.D.

M. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138
U485745
Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll

City or town Herryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 7 months 13 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Herryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 N. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Lemuel Dean

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

col

Married

6.(b) Name of husband or wife

Thelma Dean

7. Birth date of
deceased (mo., day, yr.)

July 20, 1920

6.(c) If alive, give age 20 years

8. AGE:

Years

Months

Days

If less than one day

27

9

22

..... hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name Raymond Dean

13. Birthplace Cambridge, Md.

14. Maiden name Missouri Fletcher

15. Birthplace Cambridge, Md.

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)Date thereof May 15/48
(month) (day)

Cemetery or crematory Old Field Cemetery

Location Dorchester Co. Md.

18. Funeral director

Robert E. Wallino

Address 155 McDowell St

19. May 12

48

Abraham Frankhauser

(Date rec'd by registrar)

19.

Local Deputy

Registrar

3. (b) Social Security Number

220-01-1905

A.

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 12

19 48 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 29 1944 to May 12 1948

19 48

and that I last saw h. im. alive on May 12 1948

19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

June

1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

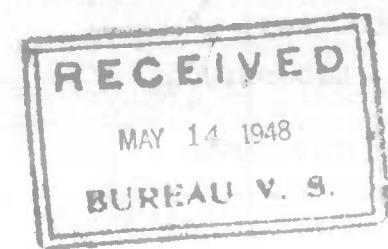
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 5/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bc

CERTIFICATE OF DEATH

Reg. Dist. No.

07456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County CarrollCity or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)Street No. 651 W. Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME

Reginald Bryan Dillon

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 7, 1890

8. AGE:

Years

Months

Days

If less than one day

57

8

3

hrs.

min.

9. Birthplace Granger, North Carolina
(Town, county, and state)10. Usual occupation Candy Vendor

11. Industry or business

12. Name Henry Edward Dillon13. Birthplace North Carolina14. Maiden name Celeste Stanton15. Birthplace North Carolina16. Informant Springfield State Hospital RecordsAddress Sykesville, Maryland

17. Burial

Date thereof May 15, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Springfield Hospital Cem.Location Sykesville, Md.18. Funeral director O'Stany SteerAddress Sykesville, Md.19. May 15, 48 (Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948 at 10:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 1948 to May 10 1948and that I last saw him alive on May 10 1948Immediate cause of death Coronary occlusion

DURATION

1 hourDue to Arteriosclerosis

Due to

Other conditions Psychosis, probably due to alcoholism
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

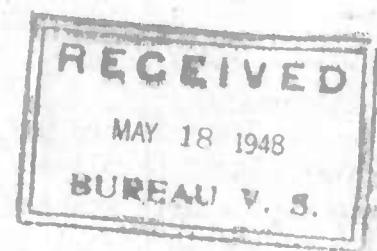
M'seue of injury

Injured at work?

23. SIGNATURE Ilse Kamm, M.D.M.D. or other Ide Kamm, M.D.

Springfield State Hospital

Address Sykesville, Maryland Date signed 5-15-48



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
and birth date shown on: 2411 N. Charles St., Baltimore
File No. G. 115 MAY 18 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 14857

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 3 months 6 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 18 yrs. 3 months 6 days

3. (a) FULL NAME

Driscoll, Patrick

(Patrick Driscoll)

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife: - - -

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 16, 1889 - 1899 1882

8. AGE: Years

Months

Days

If less than one day

66 59

1

18

hrs.

min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual occupation laborer

11. Industry or business - - -

MOTHER FATHER 12. Name Jeremiah Driscoll

13. Birthplace Ireland

14. Maiden name Mary Buttiner, dec.

15. Birthplace Ireland

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/7/48

(month) (day) (year)

Cemetery or crematory New Cathedral

Location Edmondson Avenue, Balto: Md.

18. Funeral director George J. Ruth, Inc.

Address 1735 Harford Avenue

19. 5/5 1948

(Date rec'd by registrar)

G. H. Hedrick
mea
aet
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County - - -

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -

(If rural, give LOCATION)

2.(a) If veteran, name war: - - -

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948, at 9:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to May 3, 1948

and that I last saw him alive on May 3, 1948

Immediate cause of death

Chronic myocarditis and myocardial degeneration

DURATION

1 yr.

Due to: - - -

Due to: - - -

Other conditions Coronary occlusion

1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: - - -

Date of op: - - -

Autopsy results: - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Martin Gross, M. D. M. D. or other
Address Sykesville, Maryland Date signed 5/4/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04887

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Carroll

Elmow Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Albert Ray Huddear

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15 1948 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 1948 to May 15 1948 and that I last saw him alive on May 11 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

Due to arteriosclerotic Cardio-
vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

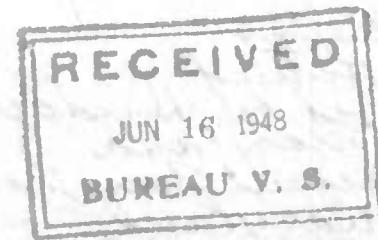
Injured at work?

23. SIGNATURE

Merritt E. Robertson

M. D. or other

Address New Windsor, Md. Date signed May 15, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04859

CERTIFICATE OF DEATH

85
Reg. Dist. No. 74

1. PLACE OF DEATH:

County

Carroll

City or town

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs 5 mos 1 day

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

20 yrs 6 mos 1 day

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 25 - 1910

5. (c) If alive, give age

years

8. AGE:

87

Years

Months

Days

If less than one day

87

4

7

hrs.

87

7

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Sam

Slacken

13. Birthplace

Md.

14. Maiden name

Sarah

Wetzel

15. Birthplace

Md.

16. Informant

Morton

W. C.

Eyer

Burial

Springfield

Hospital

Cemetery or crematory

Crematory

Cremation

Cremation

18. Funeral director

Harry

Neer

Address

Sykesville

Md.

19. May 6

1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Emmitsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

100

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3d 1948 at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2d 1947 to May 3d 1948

and that I last saw him alive on May 3d 1948

Immediate cause of death

Due to

Cerebral

Due to

Cerebral

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

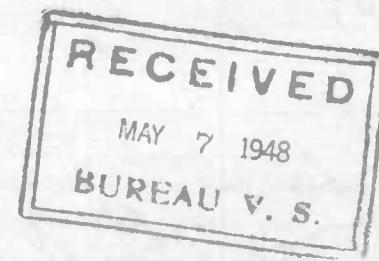
Injured at work?

23. SIGNATURE

M. D. or other

Address

Sykesville Md. Date signed 5/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04860

CERTIFICATE OF DEATH

93a
Reg. Dist. No. 75

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Longview Nursing Home

How long in hospital or institution?

18 days

3. (a) FULL NAME

M. Katherine Fiszel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 29-1878

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
7d 7y

hrs. min.

9. Birthplace

Sam's Creek, New Windsor

(Town, county, and state)

10. Usual occupation

Retired school teacher

11. Industry or business

Ephraim Fiszel

Gettysburg Pa.

14. Maiden name

Mattilda Fiszel (?)

Gettysburg Pa.

15. Birthplace

Gettysburg Pa.

16. Informant

Mrs. William S. Foiseman

6030 Broadbent Rd - Chevy Chase D.C.

17. Burial

Date thereof June 1, 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

(month) (day) (year)

Cemetery or crematory

Pope Creek Cemetery

Location

Minister, Carroll Co. Md.

18. Funeral director

J. E. Drayton Jr.

Address

Westchester Md.

19. Date rec'd by registrar

May 29 1948

M. D. or other

Address

Hampstead Md.

Date signed 5-29-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

Carroll

Westminster Md

County

(If outside city or town limits, write RURAL and give nearest town)

East Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29

1948

at 9:55 A.M.

May 29, 1948

and that I last saw her alive on

May 28

1948

1948

Immediate cause of death

Coronary Thrombosis

DURATION

5 Days

Due to

Heart B.P.C.

5 Days

Due to

Chronic Myocarditis

?

Other conditions

Senile Dementia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

—

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

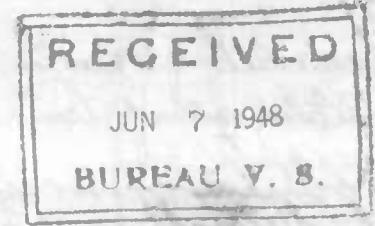
Joseph E. Bush Jr.

M. D. or other

Address

Hampstead Md.

Date signed 5-29-48



Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04861

81.

FILM No. G 116 JUN 21 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Carroll

Glencoe Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Rural #1

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Rufus Fuss

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

White Widowed

6. (b) Name of husband or wife

Jane Edna Jones

7. Birth date of
deceased (mo. day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

89

2

15

hrs.

min.

9. Birthplace

Carroll County, Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

MOTHER FATHER

John Fuss

12. Name

Elizabeth Woods

13. Birthplace

Maryland

14. Maiden name

Elizabeth Woods

15. Birthplace

Maryland

16. Informant

Paul R. Fuss

Address

Glencoe Bridge, Md.

17. Burial, cremation, or removal, Which?

Cemetery or crematory

Location

Glencoe Bridge, Md

18. Funeral director

Hartzer & Sons

Address

Glencoe Bridge, New Glencoe, Md

19. Date read by registrar

May 7, 1948

(Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

7000

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7

19

48 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2, 1948, to May 7, 1948

and that I last saw him alive on May 6, 1948

Immediate cause of death

Chronic myocarditis

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Fuss

M. D. or other

Address

Glencoe Bridge, Md. Date signed 5-7-48

RECEIVED

JUN 16 1948

BUREAU V. S.

1 PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04862

CERTIFICATE OF DEATH

83a
Reg. Dist. No. 76

1. PLACE OF DEATH:

County..... Carroll

City or town..... Westminster, route 5

(If outside city or town limits, write RURAL and give nearest town)

3 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Henry Gesell

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Blanche E. Autz

7. Birth date of deceased (mo., day, yr.) September 14, 1883

8. AGE: Years Months Days It less than one day
64 7 29 hrs. min.

9. Birthplace..... Catonsville, Md.

(Town, county, and state)

10. Usual occupation..... carpenter

11. Industry or business

12. Name..... August Gesell

13. Birthplace..... Holland

14. Maiden name..... Elizabeth Zelner

15. Birthplace..... Maryland

16. Informant..... Blanche E. Gesell

Address..... Westminster, Md.

17. burial Date thereof..... 5/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Trinity Lutheran Cem.

Location..... near Smallwood, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Route 5.

(If rural, give LOCATION)

2.(a) If veteran, name war..... none

3. (b) Social Security Number

218-10-4229

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 1948, at 11a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1948, to May 13, 1948, and that I last saw him alive on May 13, 1948.

Immediate cause of death.....

Acute cerebral hemorrhage 2 days

Due to..... Chronic Hypertension Disease 1 year

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

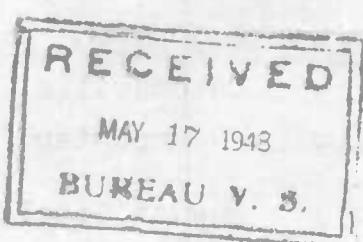
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

H. Luther Ban (M.D.)
M. D. or other
Address..... Westminster, Md. Date signed 5/13/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04863

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M
The correct age

PLEASE WRITE PLAINLY, WITH BLACK ADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

1. PLACE OF DEATH:

County... Carroll

City or town... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month, 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

SAMUEL ERNEST GREEN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

Divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 5, 1892

8. AGE:

Years

Months

Days

If less than one day

55

10

8

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

12. Name.....

Lewis Green

13. Birthplace.....

Wilmington, Delaware

14. Maiden name.....

Matilda Peterson

15. Birthplace.....

Unknown

16. Informant.....

Address

17. Burial.....

Date thereof May 21, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Location.....

Gary, Indiana

18. Funeral director.....

C. Harry Weer

Address

Sykesville, Md.

19. 5/13

19. 48

Deputy Local Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Talbot

City or town... Avalon

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

365-18-9854

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13, 1948, at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 14, 1948, to May 13, 1948,

and that I last saw him alive on May 13, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

June 1947

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

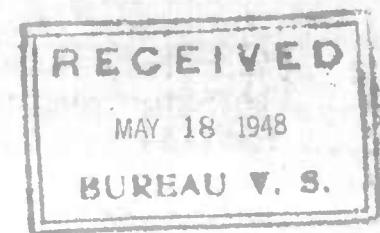
23. SIGNATURE.....

Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md.

Date signed 5/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04864

74

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 14 days

3. (a) FULL NAME

Sara Mary Gumpman

4. Sex: female	5. Color or race: white	6. (a) Single, married, widowed, or divorced: separated
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8. (b) Name of husband or wife: Joseph Gumpman

8. (c) If alive, give age: years

7. Birth date of deceased (mo. day, yr.): December 1, 1884

8. AGE: Years: 63	Months: 5	Days: 3	If less than one day hrs. min.
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9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

MOTHER FATHER
12. Name: John Roberts
13. Birthplace: England

MOTHER
14. Maiden name: Margaret Cary
15. Birthplace: Ireland

16. Informant: Springfield Hospital records
Address: Sykesville, Maryland

17. Burial: Date thereof: 5/8/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: George W. Little
Address: 2700 Edmondson Ave.

19. Date rec'd by registrar: May 5, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No: 723 Linnard Street

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1948, at 12:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20, 1948, to May 4, 1948,

and that I last saw her alive on May 4, 1948.

Immediate cause of death: Generalized arteriosclerosis

DURATION

?

Due to: Hypertension

?

Due to:

Other conditions: Bronchial pneumonia

1 day

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer, M.D. - M. D. or other

Address: Sykesville, Md. Date signed: 5-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04865

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County CarrollCity or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Haines Sr.4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Sarah Ellen Witman

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 18546. (c) If alive, give age years

8. AGE:

Years 93Months 8Days 8

If less than one day

hrs. min.9. Birthplace Fredrick Co. Md.

(Town, county, and state)

10. Usual occupation Cooper

11. Industry or business

12. Name Daniel Haines13. Birthplace Fred. Co. Md.14. Maiden name Barbara Boston15. Birthplace Fred. Co. Md.16. Informant Katherine NortonAddress Westminster 5: Md.17. Burial Burial

(Burial, cremation, or removal. Which?)

Date thereof May 11 1948

(month) (day) (year)

Cemetery or crematory MethodistLocation Detour, Md.18. Funeral director H. Bankard & SonAddress Westminster, Md.19. 9/11/48 ET

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CarrollCity or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. RP # 5-

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 10th 1948 at —21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1st 1947 to May 10th 1948 and that I last saw him alive on May 8th 1948.

Immediate cause of death

cardio-Respiratory
vascular
sluiceDue to sensitivity

Due to

Other conditions acute appendicitisof urine

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE V. J. Billingsley M.D. M. D. or otherAddress Westminster, Md. Date signed 5-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04866
136

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months, 5 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

3. (a) FULL NAME

FLORINE HARDY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Col.

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 1, 1926

8. AGE:

Years

Months

Days

If less than one day

21

10

9

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

12. Name Robert Hardy

13. Birthplace Virginia

14. Maiden name Annie Mae Williams

15. Birthplace Unknown

16. Informant Deceased

Address

Burial

Date thereof 5/13/48

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Mt. Calvary Am. B.

16. Funeral director

Address

A. H. Hause

918 Dunn Hill Ave

May 10, 1948

(Date rec'd by registrar)

Albert R. Franklin

Local Deputy

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore - 1-

(If outside city or town limits, write RURAL and give nearest town)

Street No. 811 N. Pierce Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

215-24-7355

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1948, 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1948, to May 10, 1948, and that I last saw her alive on May 10, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Oct.

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

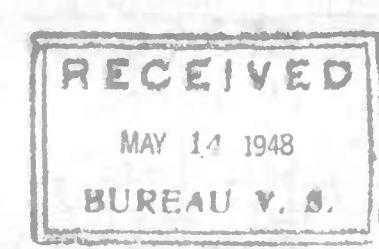
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 5-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138

04867

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 19 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton

How long in hospital or institution? 1 month

3. (a) FULL NAME

Clementine Susie Harris4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 27, 19148. AGE: Years 33 Months 9 Days 27 If less than one day
hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Cook

11. Industry or business

12. Name Harris Thompson13. Birthplace Churchton, Maryland14. Maiden name Edna Thompson15. Birthplace Churchton, Maryland16. Informant Deceased

Address

17. Burial Date thereof 5-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Young CemeteryLocation Baltimore, Md.18. Funeral director Katherine D. WilliamsAddress 3224 Schroeder St19. May 24 1948 Abbie R. Swankham
(Date rec'd by registrar) Local Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 N. Schroeder Street

(If rural, give LOCATION)

(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH May 24 1948 at 4:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1948, to May 24 1948, and that I last saw her alive on May 24 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

June 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Reuben Thompson, M.D. M. D. or otherAddress Henryton, Maryland Date signed 5/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04868

131a

CERTIFICATE OF DEATH

Reg. Dist. No.

70

1. PLACE OF DEATH:

County

Carroll

City or town

Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

50 yrs

Hospital, institution, or street address where death occurred

J

How long in hospital or institution?

J

3. (a) FULL NAME

Mrs Emma Viola Hawk

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

6. (b) Name of husband or wife

Clarence H. Hawk

7. Birth date of deceased (mo., day, yr.)

Jan 25, 1885

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

It less than one day

63

3

29

hrs.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Wm J. Smith

12. Name

M

me

13. Birthplace

Md

14. Maiden name

Emma J. Hesson

J

15. Birthplace

Md

16. Informant

Clarence H. Hawk

17. Address

Taneytown, Md.

18. Burial

Burial

Date thereof

May 27, 1948

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

Lutheran

Location

Taneytown, Md.

19. Funeral director

Ed. Johnson

Address

Taneytown, Md.

20. Date of death

May 27, 1948

(Date signed by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

E.D.S.T.

20. DATE OF DEATH

May 24

1948

at

8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20, 1947, to May 24, 1948

and that I last saw her alive on May 24, 1948

Immediate cause of death Cardiac Failure

DURATION

Due to

Uremia

Due to

Chronic cardio-vascular renal

disease

Other conditions

Severe hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

—

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident

suicide

or homicide

—

Date of

Where did injury occur

(City or town)

—

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

—

Injured at work

23. SIGNATURE

W.C. Bradley

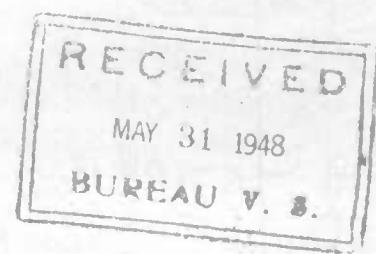
M. D. *W.C. Bradley*

Address

Taneytown, Md.

Date signed

5-26-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04869

CERTIFICATE OF DEATH

74

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Carroll

County

Henryton, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

7 Months, 3 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch

How long in hospital or institution?

3. (a) FULL NAME

(MANSEN) ANDERSON HEATH

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Margaret Heath

45

years

7. Birth date of deceased (mo., day, yr.)

June 14, 1900

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

47

11

2

hrs.

min.

9. Birthplace

Chester Co., S. Carolina

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Robert Heath

FATHER

12. Name

Chester Co., S. Carolina

MOTHER

13. Birthplace

Sealie Lewis

14. Maiden name

Chester Co., S. Carolina

15. Birthplace

Deceased

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

5/20/48

Cemetery or crematory

Mt. Calvary

Location

Brooklyn

18. Funeral director

Elroy Wilson

Address

1000 Brantley Ave

19. May 16, 48

(Date rec'd by registrar)

Abraham J. Javitz

Local Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Baltimore 30, Maryland

(If outside city or town limits, write RURAL and give nearest town)

433 W. Henrietta Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-09-7162

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16, 1948 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13, 1948, to May 16, 1948, and that I last saw her alive on May 16, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

August 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rosen Hoffman, M.D.

M. D. or other

Address: Henryton, Md.

Date signed: 5-16-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04870

47C

FILE No. G 116 MAY 24 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

3. (a) FULL NAME

CHARLES JACKSON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 12, 1905

8. AGE: Years

Months

Days

If less than one day

42

5

7

hrs.

min.

9. Birthplace

Orange County, Va.

(Town, county, and state)

10. Usual occupation

Contractor

11. Industry or business

William Jackson

MOTHER FATHER

Orange County, Va.

13. Birthplace

Mary Brown

14. Maiden name

Orange County, Na.

15. Birthplace

Deceased

16. Informant

Address

Henryton, Md.

17. Burial
(Burial, cremation, or removal. Which?)Date thereof May 23, 1948
(month) (day) (year)

Cemetery or crematory

St. Luke's Cem.

Location

Sykesville, Md.

18. Funeral director

C. Harry Weer

Address

Sykesville, Md.

19. 5/19

19

48

(Date rec'd by registrar)

Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Disney Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-07-5558

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1948, to May 19, 1948

and that I last saw him alive on May 19, 1948.

Immediate cause of death

Bronchogenic Carcinoma

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address

Henryton, Md.

Date signed 5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04871

CERTIFICATE OF DEATH

Reg. Distr. No. 74

1. PLACE OF DEATH:

County... Carroll

City or town... Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 25 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

3. (a) FULL NAME

Alfred James Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col

Separated

6. (b) Name of husband or wife

Mary Johnson

6. (c) If alive, give age 46 year

7. Birth date of deceased (mo. day, yr.)

March 6, 1898

8. AGE:

Years

Months

Days

If less than one day

50

2

20

hrs.

min.

9. Birthplace

Hampton, Virginia

(Town, county, and state)

10. Usual occupation

Waiter

11. Industry or business

MOTHER FATHER

12. Name Henry Johnson

13. Birthplace Maryland

14. Maiden name Jennie Orange

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 24, 48

(month) (day) (year)

Cemetery or crematory Brookwood Cemetery

Location New York City

18. Funeral director

Sly G. Nelson

Address 1303. Westmore St.

19. May 26

19. 48

(Date rec'd by registrar)

Alfred R. Somers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County...

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No... 727 George Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

P.M. MEDICAL CERTIFICATION

20. DATE OF DEATH May 26

19. 48 at 10:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 31 1948, to May 26 1948

and that I last saw h. 1m. alive on May 26 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Dec. 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

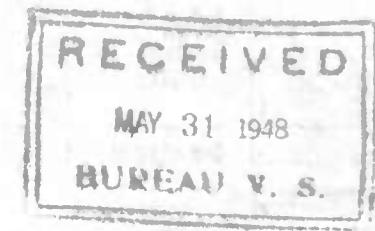
Reubenoff, M.D.

M. D. or other

Address Henryton, Maryland

Date signed

5/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04872

180
Reg. Dist. No. 82

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Carroll
County.....
City or town..... Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Horace Sylvester Johnson Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Dec. 8, 1912

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

35

4

24

hrs.

min.

Carroll Co. Maryland

9. Birthplace.....

(Town, county, and state)

Laborer

10. Usual occupation.....

11. Industry or business

Horace S. Johnson

MOTHER FATHER

12. Name.....

Maryland

13. Birthplace.....

Lucy Brown

14. Maiden name.....

Maryland

15. Birthplace.....

Horace S. Johnson

16. Informant.....

Mt. Airy, Md.

Address

17. Burial

Date thereof..... 5-4-48

(Burial, cremation, or removal. Where?)

(month) (day) (year)

Mt. Zion

Cemetery or crematory

nr. Mt. Airy, Carroll Co. Md.

18. Funeral director.....

C. M. Waltz

Address

Winfield, Md.

May 3 1948

(Date recd by registrar)

They do sayde

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Carroll

City or town..... Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

✓ (If rural, give LOCATION)
World War II

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 2

1948

at 1 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to 19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Suffocation - Second and
3rd degree burns

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Date of

Accident, suicide, or homicide

Where did injury occur? Mt. Airy, Carroll Co. Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injur

House burned

Injured at work?

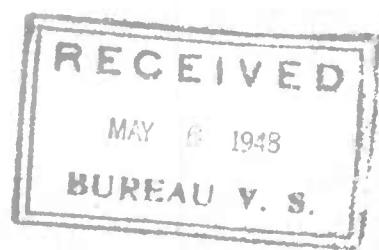
23. SIGNATURE

James T. Monk, Deputy Medical Examiner
Washington, D.C. May 2 1948

M. D. or other

Address

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04873

1318

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Carroll

City or town Towsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Noah Baldwin Kiehl

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Aenea M. Kiehl

6. (c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

Feb. 7 - 1859

8. AGE:

Years

89

Months

2

Days

27

If less than one day

hrs.

min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Farmer, Ret.

11. Industry or business

Not known

MOTHER FATHER

12. Name

Not known

13. Birthplace

Not known

14. Maiden name

Not known

15. Birthplace

Not known

16. Informant

Noah Kiehl

Address

Warfieldabury, Md.

17. Burial

Date thereof

May 7, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Woodlawn Branch Cemetery

Location

Westminster, Md.

18. Funeral director

H. B. Burkard

Address

Westminster, Md.

19. (Date rec'd by registrar)

5/6/48

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Carroll

City or town

Warfieldabury (If outside city or town limits, write RURAL and give nearest town)

Street No.

11. Warfieldabury (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

5-4-48 19 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1948, to May 4, 1948

and that I last saw him alive on May 3, 1948

19

Immediate cause of death

Myocarditis (ch)
Nephritis (ch)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Jernette, M.D. or other

Address

Westminster, Md. Date signed 5-5-48

RECEIVED
MAY 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

PC

04874

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 month, 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 246 Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

3. (a) FULL NAME

THELMA ELIZABETH LACEY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

colored

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 31, 1913

8. AGE:

Years

Months

Days

If less than one day

34

9

13

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Laundry Worker

11. Industry or business

MOTHER FATHER

12. Name

Edward Lacey

13. Birthplace

Saxe, Virginia

14. Maiden name

Jesse Bouldin

15. Birthplace

Randolph, Va.

16. Informant

Deceased

Address

17. Burial

Date thereof May 17, 1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Mt. Calvary Cem
Annapolis Road

Location

18. Funeral director

Address

19. 5/14 1948

(Date rec'd by registrar)

Albert R. Jernigan
Deputy Mayor
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 246 Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1948, at 1.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1947, to May 14, 1948,

and that I last saw her alive on May 14, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

April 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

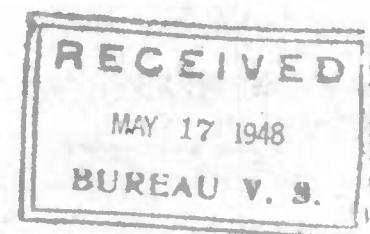
Means of injury

Injured at work?

23. SIGNATURE... Nealeen Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 5/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04875

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 yrs

Hospital, institution, or street address where death occurred:

18 Johns St.

How long in hospital or institution?

3. (a) FULL NAME

George Piss Little

4. Sex

M

5. Color or race

W

6. (b) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary G. Garrett

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

April 3-1863

8. AGE:

85

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Carroll Co - Md.

(Town, county, and state)

10. Usual occupation

Proprietor - Dry GoodsRetired

11. Industry or business

Piss & Little

12. Name

Mc. Sherrystown, Pa.

13. Birthplace

Not Known

14. Maiden name

Not Known

15. Birthplace

Henry E. Little

16. Informant

18 Johns St. Westminster, Md.

Address

17. Burial

3-20-1948

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. ✓ 17 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Johns

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 17th 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

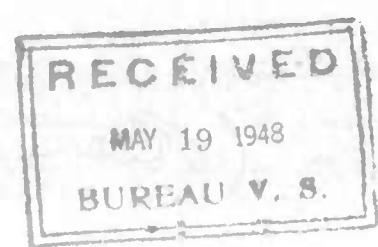
May 16, 1948 to May 17, 1948and that I last saw him alive on May 16, 1948

Immediate cause of death

Home MyocarditisArteriosclerosisDiabetes Mellitus

Due to

Diabetes Mellitus 10 yrsArteriosclerosisHome MyocarditisDiabetes Mellitus 10 yrs



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC

04876

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

Carroll

County

Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 361 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 361 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Baltimore

City or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1729 Guilford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name wnr.

3.(a) FULL NAME

Virginia Catherine McCauley

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife

Martin Luther McCauley

(deceased)

6.(c) If alive, give age

year

7. Birth date of

deceased (mo. day yr.)

September 17, 1877

8. AGE:

Years

Months

Days

If less than one day

70

7

23

..... hrn.

..... min.

9. Birthplace Agusta, County, Virginia

(Town, county, and State)

10. Unusual occupation Housewife

11. Industry or business None

12. Name Frank Taylor

13. Birthplace Agusta County, Virginia

14. Maiden name Sarah Jane Farber

15. Birthplace Agusta County, Virginia

16. Informant Mrs. Sarah Jane Altman

Address 2 Pinehurst Circle, N.W. Wash. D.C.

17. Burial

Date thereof May 11, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Edmar Manor, Md.

18. Funeral director William J. Waller

Address 3200 - R. I. Ave. Mt. Rainier, Md.

19. May 9, 1948

(Date rec'd by registrar)

Harry Steer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Baltimore

City or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1729 Guilford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name wnr.

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1948

19. 48, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above named; that I attended deceased from

May 6

1948

to May 8

1948

and that I last saw her alive on May 8

1948

Immediate cause of death Myocardial Degeneration
and failure

DURATION

X

4 days
undet.

Due to Hypertensive Heart Disease

11 yrs.

Due to Diabetes Mellitus

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Morton Jacobs M.D.

M. D. or other

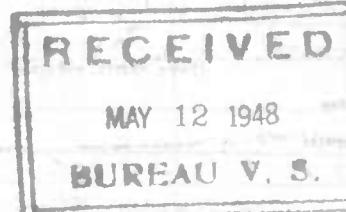
Address Springfield State Hospital, signed 8 May

in signed

MANUFACTURE STATE DEPARTMENT OF DEFENSE

1948, 15, 1948

CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04877
76

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Carroll
City or town M. Westminster - *Rural*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 1/2 months*Hospital, institution, or street address where death occurred: *Carroll Co. Jane*How long in hospital or institution? *2 1/2 mos.*

3. (a) FULL NAME

JOHN P. MILLER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6. (b) Name of husband or wife	6. (c) If alive, give age
Martha Miller	years deceased

7. Birth date of deceased (mo., day, yr.)	Sept. 15, 1857
---	----------------

8. AGE: Years	Months	Days	If less than one day
90	8	16	hrs. min.

9. Birthplace	Carroll Co. Md.
(Town, county, and state)	

10. Usual occupation	Retired
----------------------	---------

11. Industry or business	
--------------------------	--

12. Name	Unknown
13. Birthplace	

14. Maiden name	Unknown
-----------------	---------

15. Birthplace	
----------------	--

16. Informant	J. Donald Miller
---------------	------------------

Address	Woodbine, Md.
---------	---------------

17. Burial	Date thereof	6-2-48	
(Burial, cremation, or removal, where?)	(month)	(day)	(year)

Cemetery or crematory	Bethel Church of God
Location	Winfield, Carroll Co. Md.

18. Funeral director	C. M. Waltz
Address	Winfield, Md.

19. (Date rec'd by registrar)	Ray Fagle
19. (Date rec'd by registrar)	Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural --- Woodbine

(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 31, 1948, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-10-1948 to 5-31-1948
and that I last saw him alive on 5-30-1948
Immediate cause of death *Cardiac disease due to arteriosclerosis of coronary arteries*
DURATION *3 days*

Due to: *Myocardial infarction*Due to: *Arteriosclerosis*Other conditions: *Arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings or operations: *Myocardial infarction* Date of op. *5-31-48*Autopsy results: *Yes*

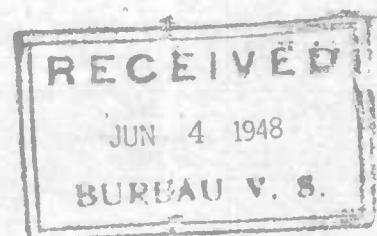
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *No* Date of *5-31-48*Where did injury occur? *Woodbine* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury *Arteriosclerosis* Injured at work? *No*23. SIGNATURE *Dr. C. A. Stoye* M. D. or other *MD*Address *Woodbine, Md.* Date signed *5-31-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 76

04878

76

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 yrs

Hospital, institution, or street address where death occurred:

68 madison

How long in hospital or institution?

3. (a) FULL NAME

Noah Joseph Miller

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Lizzie P. Frutte

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

Dec. 20 - 1870

8. AGE:

77

3

2

days

If less than one day

hrs.

min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Cigar maker

11. Industry or business

George P. Miller

MOTHER FATHER

12. Name

George P. Miller

13. Birthplace

Md.

14. Maiden name

Mathurine Keeney

15. Birthplace

Md.

16. Informant

Lizzie P. Miller

Address

68 madison St. Westminster, Md.

17. Burial

Burial

Date thereof

May 24-1948

(month)

(day)

(year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Westminster Cemetery

Location

Westminster, Md.

18. Funeral director

H.B. Banks & Son

Address

Westminster, Md.

19. (Date rec'd by registrar)

May 22-1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 68 madison

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5-22-48 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19-48, to May 23-48

and that I last saw him alive on May 21-48.

19.

Immediate cause of death

Myocarditis (ch) /
Nephritis (ch)

DURATION

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings or operations

May

Date of op.

Autopsy results

PHYSICIAN: Please describe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Fire

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Jernette, M.D.

M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1948
04873

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Mon., 2 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

3. (a) FULL NAME

ESTELLE MURRAY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Married

6. (b) Name of husband or wife William Murray

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 5, 1902

8. AGE: Years Months Days If less than one day
45 11 18 hrs. min.9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Factory

11. Industry or business

12. Name Stewart Custus

13. Birthplace Virginia

14. Maiden name Florence Purnell

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial Date thereof 5-16-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist Wardlaw

Location New Church, Va (Rural)

18. Funeral director Stevens & Watson

Address Pocomoke City, Md

19. May 23, 1948
(Date rec'd by registrar) Local Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Stockton

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-24-4618

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1947, to May 23, 1948, and that I last saw her alive on May 23, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

March 7, 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Offman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 5-23-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04880

CERTIFICATE OF DEATH

180
82

Reg. Dist. No.

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Carroll
 City or town..... Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Gloria Jean Myers
 4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Single

3. (b) Social Security Number

6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... Sept. 8, 1946
 8. AGE: Years..... 1 Months..... 7 Days..... 24 If less than one day..... hrs..... min.....

9. Birthplace..... Carroll Co. Maryland
 (Town, county, and state)
 None

10. Usual occupation.....

11. Industry or business..... Harrison Myers

MOTHER FATHER
 12. Name..... Maryland
 13. Birthplace..... Washola Johnson

14. Maiden name..... Maryland
 15. Birthplace..... Horace S. Johnson

16. Informant..... Mt. Airy, Md.
 Address.....

17. Burial..... 5-4-48
 (Burial, cremation or removal, which?)..... Date thereof..... (month) (day) (year)
 Cemetery or columbarium..... Mt. Zion

Location..... Nr. Mt. Airy, Md. Carroll Co.

18. Funeral director..... C.M. Waltz
 Address..... Winfield, Md.

19. May 3, 1948 *Hand signed*
 (Date rec'd by registrar) *Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2, 1948, at 1 A.M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
 to
 and that I last saw her alive on
 Immediate cause of death.....

Suffocation. Seems, 8th degree burns

DURATION
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

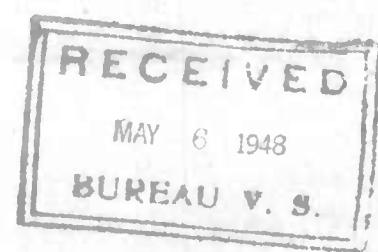
Major findings of operations..... *None*
 Date of op.

Autopsy results..... *None*
 Date of
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... *Accident* Date of
 Where did injury occur? *At Avery Avenue* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Home*
 Means of injury *of house burned* Injured at work? *No*

23. SIGNATURE *James & Thorleif Rydell*
 M. D. or other *Widower*
 Address Date signed May 1-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04881
138

74

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Carroll

County

Henryton, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

2 Months, 8 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution?

3. (a) FULL NAME

MATTIE BELLE PITTMAN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Married

6. (b) Name of husband or wife Henry Leroy Pittman

29

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) December 5, 1921

8. AGE: Years Months Days If less than one day
26 5 6 hrs. min.

9. Birthplace Georgetown, S. Carolina

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

Nathaniel Gasque

12. Name Georgetown, S. Carolina

13. Birthplace

Mary Trapper

14. Maiden name

Georgetown, S. Carolina

15. Birthplace

Deceased

16. Informant

Address

Burial Date thereof 5/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Brooklyn Mid-
City C. Wilson

18. Funeral director

1000 Brantley Ave

May 11, 1948 About 8:30 a.m.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State County

City or town Baltimore - 23-

(If outside city or town limits, write RURAL and give nearest town)

527 N. Mount Street

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

243-18-8078

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH May 11, 1948 at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 3, 1948 to May 11, 1948

and that I last saw her alive on May 11, 1948

Immediate cause of death.

Pulmonary Tuberculosis

DURATION

Jan. 1948

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

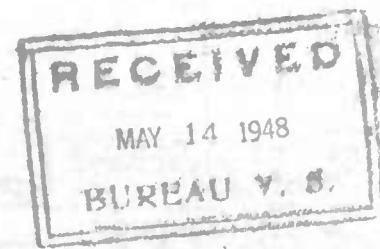
23. SIGNATURE

Reuben Offner, M.D.

M. D. or other

5-11-48

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct way is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of date
of birth: Statement of
Undertaker. 5/17/48 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

04882

74

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

1 yr 5 mo 10 da

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Benton Hood Potter

7. Birth date of
deceased (mo., day, yr.)

6.(c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

73 3 19 hrs. min.

9. Birthplace.....

(Town, County and state)

10. Usual occupation.....

11. Industry or business

12. Name of

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

BRETON PLACE

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13th 1948 at 11:25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 3d 1946 to May 13th 1948

and that I last saw her alive on May 13th 1948

Immediate cause of death.....

Coronary Thrombosis ?

Due to.....

Arteriosclerosis 70 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... May 13th 1948 Date signed.....

5/14/48 1948 A.W. Hedrick
Registrar

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04883

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs. 2 months 17 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 6 yrs. 2 months 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: Reaney, Charles H.
4. Sex: male Color or race: white 6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Mary A. Myers
7. Birth date of deceased (mo. day. yr.): December 1, 1863
6.(c) If alive, give age: --- years
8. AGE: Years: 84 Months: 5 Days: 26 If less than one day: hrs. min.
9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business: ---
MOTHER FATHER
12. Name: Alexander Reaney
13. Birthplace: Baltimore, Maryland
14. Maiden name: Virginia Forsythe
15. Birthplace: Baltimore, Maryland
16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland
17. Burial: Date thereof: May 29, 1948
(Burial, cremation, or removal Which?) (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Baltimore Md.
18. Funeral director: Milton Schubling
Address: 3914 S. Hanover St.
19. Date rec'd by registrar: May 27, 1948
(Date rec'd by registrar) Cottarey Steer
Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1948, at 2:35 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to May 26, 1948, and that I last saw him alive on May 26, 1948.

Immediate cause of death: Chronic myocarditis and myocardial degeneration
Due to: Arteriosclerosis
Due to: ---
Other conditions: Senile psychosis
(Include pregnancy within 8 months of death)

Major findings of operations: --- Date of op: ---

Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur: --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of Injury: --- Injured at work? ---

23. SIGNATURE: Martin Gross, M.D.
Address: Sykesville, Maryland Date signed: 5/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The accuracy of the information is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04884

83

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... Woodbine
 (If outside city or town limits, write RURAL and give nearest town) 7 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Carroll
 State..... County.....
 City or town..... Woodbine
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

3. (a) FULL NAME
 MAYNIE V. RIDGELY

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 C. Herbert Ridgely
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) Sept. 5, 1894 6. (c) If alive, give age 54 years
 8. AGE: 53 Years 8 Months 2 Days If less than one day
 hrs. min.
 Carroll Co. Maryland
 9. Birthplace.....
 (Town, county, and state)
 Housewife
 10. Usual occupation.....
 11. Industry or business

MOTHER FATHER	12. Name.....	Francis T. Buckingham
	13. Birthplace.....	Maryland

MOTHER	14. Maiden name.....	Ellen V. Mills
	15. Birthplace.....	Maryland

10. Informant	Mr. C. Herbert Ridgely
	Address..... Woodbine, Md.

17. Burial	Date thereof.....	5-10-48
	(Burial, cremation, or removal, Where?)	(month) (day) (year)

Cemetery or crematory..... Location.....	Morgan Chapel
	Day, Carroll Co. Maryland

18. Funeral director..... Address.....	C. M. Waltz
	Winfield, Md.

19. Date rec'd by registrar)	48	Edna M. Hewlett
	Registrar	Date signed 5/8/48

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1948 19. at 10:29a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1948 19. to May 7, 1948 19.

and that I last saw her alive on May 7, 1948 19.

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

1 da

Due to..... Malignant Hypertension

2 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

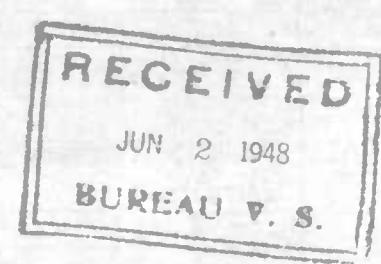
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE J. Stanley Grubill M. D. or other

Address..... Mt. Airy, Md. Date signed 5/8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. One correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138
04886

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Rural, Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs. 10 mos. 16 days

Hospital, Institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 34 yrs. 10 mos. 16 days

3. (a) FULL NAME

Amelia Ritchie

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6. (b) Name of husband or wife John Ritchie7. Birth date of deceased (mo., day, yr.) (Unknown) 1878

6. (c) If alive, give age years

8. AGE: Years 70 Months Days If less than one day
(64 in 1942)9. Birthplace (Town, county, and state) Unknown10. Usual occupation Unknown11. Industry or business PearsonMOTHER FATHER
12. Name Pearson
13. Birthplace Unknown14. Maiden name Unknown
15. Birthplace16. Informant Hospital records

Address

17. Burial Date thereof May 29, 1948
(Burial, cremation, or removal. Which?) Springfield

(month) (day) (year)

Cemetery or crematory Springfield
Location Sykesville, Md.18. Funeral director Harry Keer
Address Sykesville, Md.19. May 28, 1948 Harry Keer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1948 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1943 to May 28, 1948 and that I last saw her alive on May 27, 1948.

Immediate cause of death

Coronary thrombosis Flu minutes
Generalized arteriosclerosis 2

Due to

Pulmonary tuberculosis 8 yrs

Other conditions

Seizures, hiccups 35 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

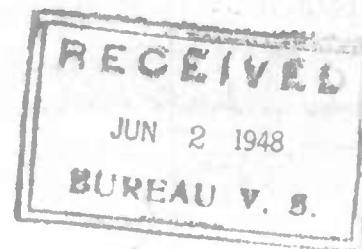
Means of injury

Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D. M. D. or otherAddress Springfield State Hospital Date signed 5/29/48

1948
70

1948
64
70



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04887

138
Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Carroll

City or town

Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 month 2 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton

How long in hospital or institution?

3. (a) FULL NAME

Cleveland Will Scott

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col.

Married

6. (b) Name of husband or wife

Mattie Scott

7. Birth date of deceased (mo. day. yr.)

January 4, 1923

6. (c) If alive, give age 22 years

8. AGE:

Years

Months

Days

If less than one day

25

4

4

hrs. min.

9. Birthplace

Bishopville, S. Carolina

(Town, county, and state)

10. Usual occupation

Contractor

11. Industry or business

MOTHER FATHER

12. Name Eli Scott

13. Birthplace Bishopville, S. Carolina

14. Maiden name Emma Eckles

15. Birthplace Bishopville, S. Carolina

16. Informant

Deceased

Address

Slipped

17. Burial, cremation, or removal. Which?

Date thereof May 17, 1948
(month) (day) (year)

Cemetery or crematory Bishopville

Location Bishopville, S. C.

18. Funeral director

Raymer Sanders

Address 1412 E. Preston St

19. May 8

19. 48

Albert R. Sanderson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3018

Seamon Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

249-24-2411

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH May 8, 1948, at 2:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947, to May 8, 1948.

and that I last saw him alive on May 8, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 5/8/48

(Date rec'd by registrar)

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04888

76

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME

Oscar David Sell4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Adah Bankert Sell7. Birth date of deceased (mo. day, yr.) Nov. 22, 1886 6. (c) If alive, give age years8. AGE: Years 61 Months 6 Days 8 If less than one day hrs. min.9. Birthplace Md (Town, county, and state)10. Usual occupation Operator Bread Route

11. Industry or business

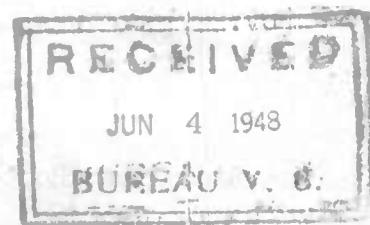
12. Name of father Levi D. Sell13. Birthplace Pa14. Maiden name Flora J. Hess15. Birthplace Md16. Informant Mrs. Oscar D. SellAddress Taneytown, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof June 3, 1948

(month) (day) (year)

Cemetery or crematory KridersLocation Westminster-Rural18. Funeral director C.O. FUSS & SONAddress Taneytown, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 76

CERTIFICATE OF DEATH

47d

04889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Carroll

City or town Westminster # 7
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carl Francis Senty

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ellie W. Fox

6. (c) If alive, give age 43 years

7. Birth date of deceased (mo. day, yr.)

April 22 - 1892

8. AGE:

56

—

13

Days

If less than one day

hrs.

min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

NoneCarroll Co. Md.14. Maiden name Mary E. BarnesCarroll Co. Md.16. Informant Ellie W. SentyWestminster 9.D. 7. Bed.17. Burial Burial Date thereof May 18-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Westminster CemeteryWestminster, Md.18. Funeral director H. Bankard SonsWestminster, Md.19. Address Westminster, Md.5/11 194819. (Date rec'd by registrar) Received Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Carroll

City or town Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 P.D. 7

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-10-3402

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 - 1948 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to May 15 1948
and that I last saw him alive on May 15 - 1948

Immediate cause of death

Common lung
Nephritis (chr)

DURATION

11 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None

Date of

Where did injury occur

None

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

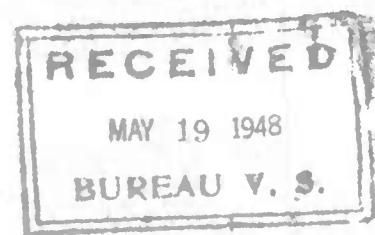
Injured at work?

23. SIGNATURE

W. C. Jernette M.D.

M. D. or other

Address Westminster 14 Date signed 5-17-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1874
Reg. Dist. No. 74

04890

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County **Carroll Co.**City or town **Henryton, Md.**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **10 days**

Hospital, institution, or street address where death occurred:

Maryland Tbc. Sanatorium**Henryton, Md.**

How long in hospital or institution?

3. (a) FULL NAME

Branch Smith

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **Dec. 25, 1896**

8. AGE: Years	Months	Days	If less than one day
51	4	26	hrs. min.

9. Birthplace **Roanoke, Va.**
(Town, county, and state)10. Usual occupation **勞工**

11. Industry or business

12. Name **Sidney Smith**13. Birthplace **Va.**14. Maiden name **Bettie Scott**15. Birthplace **Va.**16. Informant **deceased**

Address

17. Burial (Burial, cremation, or removal. Which?) **Burial** Date thereof **May 26, 1948**
(Month) (day) (year)Cemetery or crematory **U. S. National Cemetery**Location **Baltimore, Md.**18. Funeral director **Robert E. Williams**Address **1515 McElderry St**

5-21-48

19. (Date rec'd by registrar) **19.** **A. H. Smith** Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MarylandState **Maryland** County **Baltimore**City or town **Baltimore** (If outside city or town limits, write RURAL and give nearest town)Street No. **2047 Llewellyn Ave.**

(If rural, give LOCATION)

2. (a) If veteran, name war **World War I**3. (b) Social Security Number **213-16-3865**

MEDICAL CERTIFICATION

May 21, 1948 19. 2:30 a.m.

20. DATE OF DEATH May 11th. 19. 48 May 21st 19. 48

and that I last saw h. im. alive on May 21. 19. 48

Immediate cause of death Pulmonary Tuberculosis DURATION

Jan. 1948

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Reubenoff, M.D. M.D. or other

Address **Henryton, Md.** Date signed **5-21-48**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04891

CERTIFICATE OF DEATH

80

Reg. Dist. No.

1. PLACE OF DEATH: *Carroll*County: *Carroll*City or town: *Medfield*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 months*

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

*John Wilhie Smith*4. Sex: *Male* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*6. (b) Name of husband or wife: *Julia Barber*7. Birth date of deceased (mo., day, yr.): *October 23 - 1903*6. (c) If alive, give age, years: *60*8. AGE:

Years: <i>44</i>	Months: <i>6</i>	Days: <i>8</i>	If less than one day: <i>hrs. 0</i>	min. 0
------------------	------------------	----------------	-------------------------------------	--------

9. Birthplace: *Carroll County, Md.*

(Town, county, and state)

10. Usual occupation: *Farmer*11. Industry or business: *Farm*12. Name: *not known*13. Birthplace: *Unknown*14. Maiden name: *not known*15. Birthplace: *Unknown*16. Informant: *Julia Barber Smith*Address: *Medfield, Md.*17. Burial, cremation, or removal. Which? *Burial*Date thereof: *5/4/48*

(month) (day) (year)

Cemetery or crematory: *Pipe Creek Cemetery*Location: *Elmontown Road*18. Funeral director: *John H. Hartman & Son*Address: *Blisson Bridge & New Windsor Rd.*19. Date rec'd by registrar: *May 3, 1948*

(Date rec'd by registrar)

Registrar: *Ernest G. Benedict*

VS A15 9-45-15M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Maryland* County: *Carroll*City or town: *Medfield*

(If outside city or town limits, write RURAL and give nearest town)

Street No.: *Resid.*

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: *May 1, 1948* at *10:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. _____, to _____, 19. _____

and that I last saw him alive on _____, 19. _____

Immediate cause of death: *Temporary delusion*

Due to: _____

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

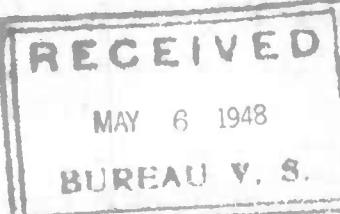
Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: *James T. Sharpe, Deputy Medical Examiner*M. D. or other: *MD* Date signed: *May 1, 1948*Address: *Westminster*



MARYLAND STATE DEPARTMENT OF HEALTH

241 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

04892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Years
Hospital, Institution, or street address where death occurred: 110 Pennsylvania Ave

How long in hospital or institution?

3. (a) FULL NAME Edward Jacob Stonerifer

4. Sex m 5. Color or race W. 6. (a) Single, married, widowed, or divorced m

6. (b) Name of husband or wife Reuben

7. Birth date of deceased (mo., day, yr.) December 21, 1884 6. (c) If alive, give age years

8. AGE: Years 63 Months 4 Days 16 If less than one day hrs. min.

9. Birthplace York County, Penna
(Town, county, and state)

10. Usual occupation Labourer Greenhouse

11. Industry or business Greenhouse

12. Name Wm Stonerifer

13. Birthplace Ind

14. Maiden name Rebecca Strickler

15. Birthplace Ind

16. Informant Wm Stonerifer

Address Washington

17. (Burial, cremation, or removal. Which?) Burial Date thereof 5-24-48
(month) (day) (year)

Cemetery or crematory 20th Street

Location Washington, D.C.

18. Funeral director Standard Corp

Address Washington

19. (Date rec'd by registrar) 5/18/48 19. 48 Registrar W. L. Bradburn

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ind County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Pennsylvania Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1948 at HISOP21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19.Immediate cause of death Coronary occlusion DURATION

Due to.

Due to.

Other conditions.

(Include pregnancy within 8 months of death)

Major findings or operations.

Autopsy results Coronary Occlusion Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

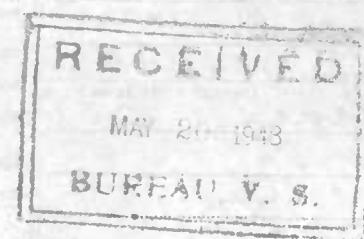
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James T. March M. D. or other ReubenAddress Washington, D.C. Date signed 5/18/48



PLEASE WRITE PLAINLY, WITH
UNFADING INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

PC
198

04893

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

3. (a) FULL NAME

JESSIE ALEXANDER STRAITEN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Hattie Straiten

7. Birth date of deceased (mo., day, yr.)

December 11, 1909

6. (c) If alive, give age 29 years

8. AGE:

Years

Months

Days

If less than one day

38

5

7

..... hrs. min.

9. Birthplace

Calvert County, Maryland

(Town, county, and state)

Laborer

10. Usual occupation

11. Industry or business

MOTHER FATHER

Joseph F. Straiten

12. Name

Calvert Co., Maryland

13. Birthplace

Frances Brown

14. Maiden name

Calvert Co., Maryland

15. Birthplace

Dedceased

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/18/48

(month) (day) (year)

Cemetery or crematory

Mt. Auburn Cemt

Location

Mt. Auburn Cemt

t8. Funeral director

Chas H. Alexander

Address

1200 McCullough

19. May 18,

(Date rec'd by registrar)

19. 48

Albert R. Branham

Local Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Street Maryland

Co.

City or town Baltimore 1

(If outside city or town limits, write RURAL and give nearest town)

Street No. 830 Bradley Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

219-05-8195

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1948

19. 48 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1948, to May 18, 1948, and that I last saw h. in alive on May 18, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

December

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Releen Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 5-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04894

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 daysHospital, institution, or street address where death occurred
Springfield State HospitalHow long in hospital or institution? 28 days

3. (a) FULL NAME

MARCULLUS WEBSTER SWEADNER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	S

8. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.) November 5, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	3	hrs. min.

9. Birthplace Frederick County, Maryland
(Town, county, and state)10. Usual occupation Bricklayer

11. Industry or business

12. Name William Sreadner13. Birthplace Frederick County14. Maiden name Frances Slifer15. Birthplace Frederick County16. Informant Hospital Records

Address

17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal. Which?)Cemetery or crematory FairmountLocation Libertytown, Md.18. Funeral director Powell & HartleyAddress 2 Woodsboro Rd19. Date rec'd by registrar May 10, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Libertytown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1948 at 3:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1948 to May 8, 1948,and that I last saw him alive on May 8, 1948,Immediate cause of death Cerebral AccidentDURATION 3 daysDue to Generalized arteriosclerosisDue to Terminal bronchopneumoniaOther conditions Psychosis with cerebral arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.

M. D. or other

Address Sykesville, Maryland Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04895

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

8 months, 17 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

8 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore City

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 W. Fayette Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

3. (a) FULL NAME

Frank Anthony Verderami

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

June 13, 1904

8. AGE: Years

Months

Days

If less than one day

43

11

2

hrs.

min.

9. Birthplace

Baltimore City

(Town, county, and state)

10. Usual occupation

Barber

11. Industry or business

Simon Verderami

MOTHER FATHER

Italy

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

Rosa ~~Verderami~~ Rinaldi

Italy

16. Informant

Springfield State Hospital Records

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/18/48
(month) (day) (year)

Cemetery or crematory

New Baltimore Cem.

Location 4300 Cedar Avenue Road

18. Funeral director

John L. Brown & Son

Address 101-63 Hollins St -

19. 5/17/48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15

48

11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 28

1947

to May 15

1948

and shall last saw him alive on

May 15

1948

Immediate cause of death Active tuberculosis
of the lungs.DURATION
8 mos.

Due to

Due to

Other conditions Schizophrenia, hebephrenic
type.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Ilse Kamm, M.D.

Springfield State Hospital M.D. or other

Address Sykesville, Maryland Date signed 5-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04896

CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

4 Months, 5 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution?

3. (a) FULL NAME

RACHEL ELIZABETH WALKER (WADE)

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.) August 1, 1920

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

27 9 13 hrs. min.

9. Birthplace: West Virginia

(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: John Walker

12. Name: John Walker

13. Birthplace: W. Virginia

14. Maiden name: Virginia Dennis

15. Birthplace: Virginia

16. Informant: Deceased

Address: Burial

17. (Burial, cremation, or removal. Which?) Date thereof: May 17, 1948

(month) (day) (year)

Cemetery or crematory: St. James

Location: Havre de Grace, Md.

18. Funeral director: T. Madison Mitchell

Address: Havre de Grace, Md.

19. May 14, 1948
(Date rec'd by registrar)

Local Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: Harford

City or town: Havre de Grace

Md.

(If outside city or town limits, write RURAL and give nearest town)

412 Freedom Street

Street No.

County

2. (a) If veteran, name war

(If rural, give LOCATION)

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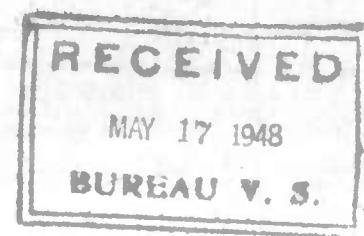
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 76

CERTIFICATE OF DEATH

552

04897
76M
The correct age
is especially important.

1. PLACE OF DEATH:
 County Carroll Co.
 City or town Purcell near Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Carroll
 City or town Purcell near Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westminster Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME Elton Wilmer Warehime
 (Signature) ?

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced widowed
 7. Birth date of deceased (mo., day, yr.) March 29. 1873
 8. AGE: Years 75 Months 1 Days 13 If less than one day
 9. Birthplace Westminster Road Westminster
 (Town, county, and state) Carroll Co. Md.
 10. Usual occupation Carpenter

11. Industry or business
 12. Name David H. Warehime
 13. Birthplace Carroll Co. Md.
 14. Maiden name Sarah Pueblo
 15. Birthplace Carroll Co. Md.

16. Informant Roger Warehime
 Address Westminster R. D. Md.
 17. Burial Burial Date thereof May 15 48
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)
 Cemetery or crematory Kniders Cemetery
 Location Near Westminster Md.

18. Funeral director J. S. Meyers Jr.
 Address Westminster Md.
 19. ✓ 14 Date record by registrar 1948 Carroll Registrar
 (Date record by registrar) ✓ (Signature) Westminster Md. Date signed 5/14/48

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1948, at 10:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to May 12 1948and that I last saw him alive on May 12 1948

Immediate cause of death Carcinoma DURATION
Left Forearm 4 mos
Secondary anemia
 Due to Cachexia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Al G. Glenny, M.D. M. D. or otherAddress Westminster Md. Date signed 5/14/48

RECEIVED

MAY 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04898

CERTIFICATE OF DEATH

70

Reg. Dist. No. 94a

1. PLACE OF DEATH:

County Carroll
City or town Carroll Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 monHospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

Theodora Warner

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Mary (Keserling) Rutherford6. (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.)

March - 29 - 1868

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

York County, PA.
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Retired Farming

MOTHER FATHER

12. Name Henry Warner13. Birthplace Jack County, PA.14. Maiden name Arabella (Warner) Warner15. Birthplace York County, PA16. Informant Edward WarnerAddress Taneytown, Md. P.D. 117. Removal for Burial Date thereof May - 31 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shaefers CemeteryLocation York County, PA.18. Funeral director J. W. Liddle & SonAddress Littlestown, PA. Rev R. A. Liddle19. Date rec'd by registrar May - 28 - 1948 Ethel M. McHenry
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty CarrollCity or town Carroll Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 28 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Coronary artery disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

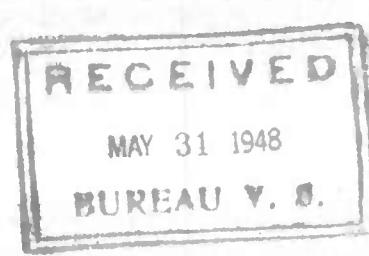
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James T. Ward Deputy Medical Examiner
M. D. or other Ward Date signed 5/28/48



PLEASE WRITE PLAINLY, WITH UXFADING INK. Supply every item of information carefully. In case
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

ac

04885

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 months

3. (a) FULL NAME

Ridinger, Robert Wesley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife: Blanche Ridinger

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age: unkn. years

October 25, 1874

8. AGE:

Years

Months

Days

If less than one day

73

6

18

hrs.

min.

9. Birthplace: Baltimore, Maryland

(Town, county, and state)

10. Usual occupation: bricklayer

11. Industry or business: - - -

12. Name: John Thomas Ridinger

13. Birthplace: Maryland, TANNEY TOWN.

14. Maiden name: Amelia Null

15. Birthplace: Maryland

16. Informant: Records of Springfield St. Hospital

Address: Sykesville, Maryland 2038 BRADDISH Av

B. & J. B.

Date thereof: 5/17/48

(month) (day) (year)

17. (Burial, cremation, or removal. Which?) Cemetery or crematory: St. JAMES

Location: CARROLL Co., MD.

18. Funeral director: Wm. T. TICKNER & Sons

Address: B. & J. B., MD.

19. (Date rec'd by registrar) 5/14/48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: - - -

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No: 2038 Braddish Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war: - - -

3. (b) Social Security Number

216-01-6554 A

MEDICAL CERTIFICATION

2D. DATE OF DEATH: May 13, 1948, at 10:35 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28, 1948, to May 12, 1948,

and that I last saw him alive on May 12, 1948.

Immediate cause of death: Chronic myocarditis and myocardial degeneration

DURATION

more than 2 months.

Due to: - - -

Due to: - - -

Other conditions: Arteriosclerosis unknown

Senile psychosis, delirious, confused - 5 yrs. (Include pregnancy within 3 months of death) type

Major findings or operations: - - -

Date of op: - - -

Autopsy results: - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - - -

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 5/13/48

Martin Gross, M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04899

CERTIFICATE OF DEATH

138-74

Reg. Dist. No.

1. PLACE OF DEATH:

Carroll

County

Henryton, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 mos. 1 day

Hospital, institution, or street address where death occurred:

Maryland Tbc. Sanatorium, Col. Branch

How long in hospital or institution?

3. (a) FULL NAME

Cardrena White

4. Sex

female

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 27, 1912

8. AGE: Years

36

Months

3

Days

23

If less than one day

hrs. min.

9. Birthplace (Town, county, and state)

Princess Anne, Md., Somerset Co.

10. Usual occupation

11. Industry or business

Will White

MOTHER FATHER

Maryland

12. Name

13. Birthplace

Emma Deshields

14. Maiden name

15. Birthplace

Maryland

16. Informant

Address

deseased

17. Burial (Burial, cremation, or removal) Which?

Burial Date thereof 5/23/48
(month) (day) (year)

Cemetery or crematory

Princess Anne Cemetery
Location Princess Anne, Md.

18. Funeral director

Address

Charles St. Croft

19. May 20, 1948

(Date rec'd by registrar)

510-12 Carvelton Ave.

19.

19.

Albert R. Savard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Somerset

City or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No. 257 Bedford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

219-07-1116

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20,

1948 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1947, to May 20, 1948

and that I last saw her alive on May 20, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

April

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 5-20-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

04960

36

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 8 month 9 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

3. (a) FULL NAME

Irez Wooded

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female col Married

6. (b) Name of husband or wife

Oscar Wooded

7. Birth date of deceased (mo., day, yr.)

October 20, 1914

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
33	6	19	hrs. min.

9. Birthplace

Wells, N. Carolina

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Gilbert Johnson

MOTHER FATHER

Unknown

13. Birthplace

Unknown

14. Maiden name

Minnie Golds

15. Birthplace

Unknown

16. Informant

Deceased

Address

Burial

Date thereof 5/13/48
(month) (day) (year)

Cemetery or crematory

9th Zion Germ.

Location

9th Z. W.

18. Funeral director

Miss Ruth B. Williams

Address

322 W. Concord St

19. May

9 1948

(Date rec'd by registrar)

Albert R. Brumfield

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH May 9

19. 48 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 30 1946 to May 9 1948

and that I last saw her alive on May 9 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Oct. 1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

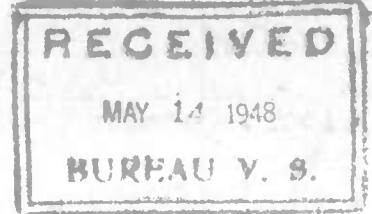
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Henryton, Maryland Date signed 5/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04981
138

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 26 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

3. (a) FULL NAME

William Nathan Wyatt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 5, 1912

8. AGE:

Years

Months

Days

If less than one day

35

5

24

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

12. Name

Thomas Wyatt

13. Birthplace

Virginia

14. Maiden name

Malinda Wheeler

15. Birthplace

Baltimore, Maryland

16. Informant

William Nathan Wyatt

Address

1612 McCulloh St. Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Not Auburndale CemeteryHenryton, Md.

Location

Bald Hill

18. Funeral director

Rev. W. J. Mallard

Address

1601 Daniel Hill Dr.

19. Date rec'd by registrar

May 291948Albert B. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Street Maryland County MarylandCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 1612 McCulloh Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

P.

2D. DATE OF DEATH

May 29

19. 48, at 8:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 3 19. 48, to May 29 19. 48and that I last saw him alive on May 29

DURATION

Pulmonary Tuberculosis

Aug.

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert Offman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 5/29/48

